women's health history

Patient name ____

Date of Birth _____/_____/_____

Menstrual history

– When was your last menstrual period (LMP) _______/_______/_______

– Has your period completely stopped? ☐ Yes ☐ No If yes, when did they stop? _______/_______/_______

If no longer menstruating, you may skip the rest of the questions in the menstrual history section.

– Are your periods regular enough to be able to predict when you will get your next period? ☐ Yes ☐ No

– How many days are between the beginning of one period to the beginning of your next menstrual period?______

– Do you have any spotting between each period? ☐ Yes ☐ No

– Do you have severe pain and cramping with your periods? ☐ Yes ☐ No

– How many days of bleeding do you have with each cycle? _______

– How many tampons or pads do you use for every day of bleeding? _______

Obstetrical history

Have you ever been pregnant? ☐ Yes ☐ No If yes, please list all your pregnancies in the list below:

Year ________ number of months _______ Outcome ☐ miscarriage ☐ abortion ☐ vag delivery ☐ c/s
Sex: ☐ female ☐ male weight _______ Hospital / Location: ______________________________
Any Complications? ☐ gestational diabetes ☐ pre-eclampsia ☐ other ______________________________

Year ________ number of months _______ Outcome ☐ miscarriage ☐ abortion ☐ vag delivery ☐ c/s
Sex: ☐ female ☐ male weight _______ Hospital / Location: ______________________________
Any Complications? ☐ gestational diabetes ☐ pre-eclampsia ☐ other ______________________________

Year ________ number of months _______ Outcome ☐ miscarriage ☐ abortion ☐ vag delivery ☐ c/s
Sex: ☐ female ☐ male weight _______ Hospital / Location: ______________________________
Any Complications? ☐ gestational diabetes ☐ pre-eclampsia ☐ other ______________________________

Year ________ number of months _______ Outcome ☐ miscarriage ☐ abortion ☐ vag delivery ☐ c/s
Sex: ☐ female ☐ male weight _______ Hospital / Location: ______________________________
Any Complications? ☐ gestational diabetes ☐ pre-eclampsia ☐ other ______________________________

Year ________ number of months _______ Outcome ☐ miscarriage ☐ abortion ☐ vag delivery ☐ c/s
Sex: ☐ female ☐ male weight _______ Hospital / Location: ______________________________
Any Complications? ☐ gestational diabetes ☐ pre-eclampsia ☐ other ______________________________

women's health history (cont')

Patient name ____

Date of Birth _____/_____/_____

Obstetrical history (cont')

Year ________ number of months _______ Outcome ☐ miscarriage ☐ abortion ☐ vag delivery ☐ c/s
Sex: ☐ female ☐ male weight _______ Hospital / Location: ________________________________
Any Complications? ☐ gestational diabetes ☐ pre-eclampsia ☐ other ______________________

Year ________ number of months _______ Outcome ☐ miscarriage ☐ abortion ☐ vag delivery ☐ c/s
Sex: ☐ female ☐ male weight _______ Hospital / Location: ________________________________
Any Complications? ☐ gestational diabetes ☐ pre-eclampsia ☐ other ______________________

Year ________ number of months _______ Outcome ☐ miscarriage ☐ abortion ☐ vag delivery ☐ c/s
Sex: ☐ female ☐ male weight _______ Hospital / Location: ________________________________
Any Complications? ☐ gestational diabetes ☐ pre-eclampsia ☐ other ______________________

Additional comments about pregnancies; ____

Gynecologic history

– Have you ever had any abnormal pap smears? ☐ Yes ☐ No
If yes, did you have? ☐ freezing of cervix ☐ LEEP ☐ cold knife cone procedure
– Have you had any sexually transmitted infections? ☐ Yes ☐ No
– Have you ever had Pelvic Inflammatory disease (PID)? ☐ Yes ☐ No
– Do you ever experience pain with intercourse? ☐ Yes ☐ No

Contraceptive history

– Are you sexually active? ☐ Yes ☐ No
– Do you use birth control? ☐ Yes ☐ No
– If yes, what type of birth control/contraceptive do you use? ______________________
– Have you ever used any other type of birth control/contraceptive? ☐ Yes ☐ No
If yes, please describe ____